

MEMBER/CLIENT ACKNOWLEDGEMENT STATEMENT

SAMPLE

“I understand that, in the opinion of \_\_\_\_\_ . The  
(Provider Name)

Services or items that I have requested to be provided to me on the

\_\_\_\_\_ may not be covered under the Community First  
(Dates of service)

STAR Medicaid Program as being reasonable and medically

Necessary for my care. I understand that I am responsible for payment

Of the services or items I requested and receive if these services or items are

Determined not to be reasonable and medically necessary for my care.”